DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **03-04**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2003**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR, Part 447, Subpart C	7. FEDERAL BUDGET IMPACT: **a. FFY 4/01/03 – 9/30/03 $(7,325,000)** **b. FFY 10/01/03 – 9/30/04 $(14,650,000)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A, Page 117(a)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A, Page 117(a)**

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Services

11. GOVERNOR'S REVIFW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Kathryn Kuhmerker	16. RETURN TO: **New York State Department of Health, Corning Tower, Empire State Plaza, Albany, New York 12237**
13. TYPED NAME: **Kathryn Kuhmerker**	
14. TITLE: **Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: June 27, 2003	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 30 2003	18. DATE APPROVED: JAN 23 2004
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR – 1 2003	20. SIGNATURE OF REGIONAL OFFICIAL: Bill Scanlon
21. TYPED NAME: William LaSowski	22. TITLE: Acting Deputy Director, CMSO

23. REMARKS:

(d) For rates of payment for discharges in 1991 and thereafter, a general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww (d)(2)(D)) or defined as a rural hospital under state law may choose to have its DRG specific operating cost component be 100 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54 (a) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart, provided however, commencing April 1, 1996 through July 31, 1996 the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2), shall be reduced by five percent, and commencing August 1, 1996 through March 31, 1997 the reimbursable impatient operating cost component of case based rates of payment per diagnosis-related group, excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2), shall be reduced by two and five-tenths percent, and commencing April 1, 1997 through March 31, 1999 and July 1, 1999 through March 31, [2003] 2005, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54 (h)(2), shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. In order to exercise this option for 1991 or subsequent rate years, the general hospital shall notify the Department of such election in writing by no later than December first of the preceding rate year or a later date as determined by the Commissioner.

(e) As for discharges on or after April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, [2003] 2005, the DRG case-based rates of payment for patients assigned to one of the twenty most common diagnosis-related groups, will be held to the lower of the facility specific amount or the average amount, as determined pursuant to subdivision (c) of this section for all hospitals assigned to the same peer group. The twenty most common diagnosis-related groups shall be determined using discharge data two years prior to the rate year, but excluding beneficiaries of title XVIII (Medicare) of the federal social security act and patients assigned to diagnosis-related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit [of] or exempt hospital patients.

(f) Effective July 1, 1995 through June 30, 1996, rates of payment for inpatient acute care services shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law, regulation promulgated in accordance with applicable standards and procedures for promulgating hospital operating standards, the Commissioner, or other governmental agency as follows:

(i) An aggregate reduction shall be calculated for each hospital based upon: the result of eighty-nine million dollars annually for 1995 and trended to the rate year, multiplied by a ratio based upon data two years prior to the rate year, consisting of hospital-specific case-based Medicaid patient days divided by total case-based Medicaid patient days summed for all hospitals.

TN 03-04 Approval Date JAN 23 2004
Supersedes TN ____ Effective Date APR 1 2003